UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

ESTATE OF RUTH FREIWALD BY PERSONAL REPRESENTATIVE CHARLES FREIWALD, et al.,	**CASE NO: 18-CV-896**
Plaintiffs,	
DEAN HEALTH PLAN, INC. and PROGRESSIVE CASUALTY INSURANCE COMPANY,	
Involuntary Plaintiffs,	
v.	
ADEYEMI FATOKI, M.D., et al.,	
Defendants.	
Defendants.	

DEPOSITION OF ALFRED JOSHUA, M.D.
San Diego, California
February 5, 2020

REPORTED BY: BOBBIE HIBBLER, CSR NO. 12475

EXHIBIT
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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

ESTATE OF RUTH FREIWALD)
BY PERSONAL REPRESENTATIVE)
CHARLES FREIWALD, et al.,) CASE NO: 18-CV-896
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Plaintiffs,)
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DEAN HEALTH PLAN, INC. and)
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INSURANCE COMPANY,)
)
Involuntary Plaintiffs,)
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v.)
)
ADEYEMI FATOKI, M.D., et al.,)
)
Defendants.)
)
)
Defendants.)
_____)

DEPOSITION OF ALFRED JOSHUA, M.D., taken by the Plaintiffs, commencing at the hour of a.m. on Wednesday, February 5, 2020, at 530 B Street, Suite 350, San Diego, California, before Bobbie Hibbler, Certified Shorthand Reporter in and for the State of California.

APPEARANCES
For the Plaintiffs:
LAWTON & CATES, S.C.
BY: DIXON R. GAHNZ, ESQ.
345 W. Washington Avenue
Suite 201
Madison, Wisconsin 53701
608-282-6200
Dgahnz@lawtoncates.com

For Defendants D. Peters, John R. Gossage and Brown County:
CRIVELLO CARLSON, S.C.
BY: STEVEN C. McGAVER, ESQ.
710 North Plankinton Avenue
Suite 500
Milwaukee, Wisconsin 53203
414-271-7722
Smcgraver@crivellocarlson.com

For Defendant Adeyemi Fatoki, M.D.:
GUTGLASS, ERICKSON, BONVILLE & LARSON, S.C.
BY: MARIA KYSELY SCHNEIDER, ESQ.
735 N. Water Street
Suite 1400
Milwaukee, Wisconsin 53202
414-273-1144
Maria.schneider@gebsc.com

For Defendants Correct Care Solutions, Emily Blozinski & Jessica Jones:
(Telephonic Appearance)
HEYL, ROYSTER, VOELKER & ALLEN
BY: ANDREW J. ROTH, ESQ.
33 N. Dearborn Street
Seventh Floor
Chicago, Illinois 60602
312-853-8700
Aroth@heylroyster.com

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EXHIBIT INDEX

ALFRED JOSHUA, M.D.,
having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. GAHNZ:

Q. Good morning. Would you state your name and spell it for the record please?

A. Sure. My name is Dr. Alfred Alexander Joshua. A-L-F-R-E-D. Last name is J-O-S-H-U-A.

Q. Doctor, I'm assuming you've given depositions before?

A. Yes.

Q. I'm not going to spend a lot of time going through the mechanics of it. But one thing that is very important is if you don't understand a question that I ask, please ask me to rephrase it or repeat it, and only answer those questions you understand. Fair enough?

A. Yes.

Q. Let's talk about what did you do to get ready for today?

A. I reviewed my expert report, my supplemental report, and then just the materials associated with what was in the report.

Q. Did you meet with counsel for

Dr. Fatoki?
A. You mean Maria?
Q. Maria.
A. Yes.
Q. Did you meet with any other attorneys?
A. No.
Q. Did you speak with Dr. Fatoki?
A. No.
Q. Have you ever spoken with Dr. Fatoki?
A. I don't believe so.
Q. Do you know Dr. Fatoki?
A. No. Not personally.
Q. At any time during -- well, let me back up. When were you first contacted about this case?
A. I believe -- I'd have to look at the records. Probably last year.
Q. At any time since the time you've been retained in this matter and today, have you spoken with any of the other attorneys for any of the other parties?
A. You mean on the plaintiff's side?
Q. No. Did any of the other -- let me break it down. Have you spoken with any of the attorneys for CCS?

A. His report.
Q. Do you know why Dr. Folks' report was sent to you?
A. Just to review the report. I did not get a chance to review it.
Q. Other than Dr. Folks' report, have you reviewed any of the other defense expert reports in this matter?
A. Only on the plaintiff side.
Q. Okay. Have you reviewed the plaintiff's experts' reports and depositions or --
A. If it's listed there. I believe all of the actual reports I definitely reviewed. But if the depositions were there and it's listed, everything in the materials reviewed I have reviewed.
Q. Who first contacted you with respect to serving as an expert in this matter?
A. I believe it was Maria.
Q. Had you worked with Maria or her firm prior?
A. No.
Q. What were you asked to do?
A. To review, you know, the records and everything related to the care that Dr. Fatoki

A. I don't believe so.
Q. Have you spoken with any of the attorneys for Brown County?
A. I don't believe so.
Q. Have you spoken with any of the attorneys for Nurse Blozinski?
A. I don't believe so.
Q. Nurse Jones?
A. I don't believe so.
Q. Have you spoken with any of the named defendants in this case?
A. No.
Q. Have you spoken with any of the other defense experts in this case?
A. No.
Q. Have you reviewed any of the defense expert reports?
A. Yes.
Q. Whose?
A. It was Dr. -- because it was sent to me yesterday. It was Dr. --
MS. SCHNEIDER: It was Folks.
BY MR. GAHNZ:
Q. Did you review Dr. Folks report or deposition?

provided and to see if it was within the standard of care.
Q. Anything else?
A. That was it.
Q. That was your task?
A. Yes.
Q. The reason I ask is you filed a supplemental report where you give opinions related to other people besides Dr. Fatoki. And my question is did the scope of your engagement change over time?
A. So the primary focus was Dr. Fatoki. But in the process of reviewing the materials there were other individuals that were as part of that. But in terms of the overall, I guess, direction of the case and everything else, my opinions are pretty similar. But Dr. Fatoki is the primary person related to the opinions.
Q. Let's ask it this way. At trial in this matter are you going to be offering opinions with respect to any of the conduct of Brown County?
A. I have not been asked to.
Q. Slightly different question. Are you planning on giving any opinions with respect to any of the Brown County defendants?

A. At this point in time, no.
Q. With respect to Nurse Jones, are you planning on giving any opinions with respect to her conduct?
A. At this point, no.
Q. With respect to Nurse Blozinski, are you planning on giving any opinions with respect to her conduct?
A. At this point, no.
Q. Last one, and this one -- and we're going a lot quicker than some of these other depositions. With respect to CCS, are you planning on giving any opinions with respect to its conduct?
A. At this point, no.
Q. Okay. Did you as part of your work in this case do any sort of a literature search?
A. So, in terms of the materials reviewed it was part of the NCCHC standards book. I believe I provided a copy of the page. But it's an entire book of standards. And then just based on my own knowledge of the medications and everything else. But those are years of reading and knowing. So I didn't do anything specifically outside of just the standards that were applicable

to this case.
Q. Okay. I'm going to show you what we marked as Exhibit 237 and ask is that your professional resume?
A. Yes, it is.
(WHEREUPON, THE ABOVE-MENTIONED DOCUMENT WAS MARKED AS EXHIBIT NO. 237 TO THE TESTIMONY OF THE WITNESS AND IS ATTACHED HERETO.)
BY MR. GAHNZ:
Q. Is it current and up to date at least as of the time you provided it in this case?
A. So at the time, yes. But since February of 2019 I'm currently the Regional Chief Medical Officer for Alvarado and Paradise Valley hospitals in San Diego.
Q. So you're the Regional Chief Medical Officer for what facility?
A. Alvarado and Paradise Valley Hospitals.
Q. When did you get that job?
A. February of 2019.
Q. What does your job entail?
A. It's clinical oversight of both hospitals. And they're acute hospitals. They also have psychiatric beds. I mean, it's a 290 bed hospital. It's one campus. And then the

other hospital is I believe has around close to 300 beds.
Q. Do either of these facilities have any ties to correctional health care?
A. So they do hospitalize custody patients from time to time. But it's not -- the hospitals do not provide contracted care inside the jails.
Q. In looking at your resume, have you authored any papers, presentations, etc., that would be particularly relevant to the issues in this case?
A. So I have done presentations.
Q. What pages are you looking at, sir?
A. If you go to the press releases as well as the presentations and speaking, I have spoken at the National Commission on Correctional Health Care related to the Inmate Safety Program. I have also spoken about mental health a number of times both in the media as well as in public speaking arrangements. And many of them based on the title you should be able to see which ones were mental health related. And then Suicide Prevention Strategies. And then if you look at No. 13 in the public speaking engagement it says National Commission on Correctional Health Association -

Inmate Safety Program. That was one that basically was pretty pertinent to this type of case.
Q. That was a presentation that you gave?
A. To, you know, a group of probably a hundred people at the National Commission of Correctional Health Care, which is a national conference on the standards and for all the leaders of many of the different jails, federal facilities, prisons together and then sees what's best practices. And so I have spoken at that conference a couple of times, but that one specific for mental health and suicide prevention.
Q. Were there written materials that you had prepared?
A. There were PowerPoints.
Q. Okay.
A. I think they were all publicly available.
Q. Have you written anything with respect to Clonazepam or benzodiazepine withdrawal?
A. No. The things I read from an article standpoint is Narcan. So San Diego County Sheriff's Department was one of the first law enforcement in the country to basically have the

officers provide Narcan to heroin overdose patients in the field. And basically that was a program that I was part of. And there was a paper that was written there. And that is No. 4 in the publications.

Q. The one with Karla DW?

A. Yes.

Q. So what was the thrust of this article is how to -- was it how to administer Narcan or when to administer Narcan? What was the article about?

A. So the article was just basically the perceptions of how law enforcement actually having Narcan, not only saved the lives, but also how the project and everything went. I did do a separate video. I don't know if it's in here related to Narcan treating specifically for the 2,000 plus deputies of the San Diego Sheriff's Department. And so everybody had to get trained. And I had to provide those training materials as well.

MR. GAHNZ: Let's go off the record for a moment.

(WHEREUPON, A BREAK WAS TAKEN AND THE PROCEEDINGS CONTINUED AS FOLLOWS:)

BY MR. GAHNZ:

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Q. We were talking about you had done a training video with respect to the administration of Narcan to the 2,000 sheriff deputies in San Diego County?

A. Yes.

Q. That is kind of where we left off?

A. Yes.

Q. Anything specific to benzodiazepines?

A. To benzodiazepines, I mean, in the process of being the chief medical officer of the San Diego Sheriff's Department over the five years I have a lot of experience related to alcohol withdrawal, benzodiazepine withdrawal related to the protocols and the people that were coming into the jails.

Q. Okay. We'll get to that in a bit. My question is a little bit more focused in terms of whether or you have written anything specific to benzodiazepine?

A. I have not published anything.

Q. So in terms of -- let's get to that now. You were talking about protocols and what not for benzodiazepine. What is your role or was your role with San Diego Sheriff's Department?

A. So I basically clinically oversaw all

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the medical mental health and dental care in San Diego County jails which had a average daily population of 5,800 people and 91,000 bookings a year. So it encompassed a number of things including policies and procedures, contract oversight, provider oversight, quality assurance, as well as operations, and then obviously for legal and other things to be of an assistance.

Q. In a previous answer you were talking about the protocols and what not that you were involved with related specifically to benzodiazepine?

A. Yes.

Q. Tell me about that?

A. So specifically when individuals would come in, and on average there would be potentially 250 inmates coming in per day, many of them would be suffering from alcohol abuse. And some of them were on long-standing benzodiazepine. So we had a protocol in place to make sure that, you know, they didn't go through life-threatening withdrawals.

Q. What was that protocol?

A. That they would potentially get a benzodiazepine taper called Librium versus

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sometimes they would be observed depending on the situation and the nurse's assessment.

Q. What is Librium?

A. Yes.

Q. I'm sorry, Librium. What is Librium?

A. It's a long-acting benzodiazepine.

Q. What was the purpose of putting the inmates on the Librium?

A. So that they wouldn't undergo life-threatening withdrawals for benzodiazepines.

Q. And is there a risk of life-threatening withdrawal if benzodiazepines are stopped abruptly?

A. Yes.

Q. So walk me through the details of how that program worked, if you had an inmate that came in where there was a question as to whether he or she was on a benzodiazepine?

A. So at that point there would be a request for records from the outside to see --

Q. I'm sorry. And I want to back you up. The person comes in. Just walk me through the first thing that happens?

MS. SCHNEIDER: I'm going to object as vague as overly broad. But go ahead.

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A. The person would then be assessed by a registered nurse at intake. And they would have a screening exam done. And in the San Diego jails there were two screenings. There was a first stage screening with a limited number of questions.

And then there was a secondary screening that goes more into the medical, mental health, substance abuse history. If it was determined at that point the person was on a benzodiazepine based on asking the inmate, the person would then sign a release of information for records of where they were getting that, whether it was a pharmacy or other places.

And then depending on the risk level, they could be put into this standard nursing protocol where the individual could potentially get Librium or be monitored based on the conditions. And then a referral to the physician or psychiatrist as needed.

BY MR. GAHNZ:

Q. Okay. So was there a form that the registered nurse used for determining the risk level?

A. At the point where I was there, there

was no clinically validated scoring, such as CIWA or COWS. CIWA is for alcohol withdrawal. And COWS is for opiate withdrawal. There's a clinical scoring system. So those were not in place at the time I was there. It was basically a standard nursing protocol with the policies and procedures, as well as the nurse's assessment of the severity of the withdrawal and the risk, and then consultation with the physician as needed.

Q. So backing up. There's a CIWA and a CIWA-B; correct?

A. Yes.

Q. CIWA-B was not -- well, backing up again. Is it your testimony that between 2013 and 2018, the CIWA scale had net been developed?

A. No. It was not used for the San Diego jails.

Q. This initial determination was that done at the booking?

A. At the intake screening. Yes.

Q. I'm wondering why you're quibbling with my words. I just want to know what's the difference between the intake screening and booking?

A. So it is part of that same process.

Q. Okay.

A. So they're coming in and they're getting their initial screening, yes.

Q. So then if it's determined that the person should be tapered off of the benzodiazepines, then how is it that the Librium is prescribed?

A. So it's basically a protocol of each day they would get a certain dosage of the Librium. And it would get less and less depending again on what was determined on the severity. Usually benzodiazepine was a pretty small amount of inmates like on an annual basis versus alcohol. So alcohol was probably the most common one. And so it was basically following that. If there needed to be consultation, a psychiatrist could be called to do a longer taper if an individual was on it at high doses or there was immediate threat.

Q. Was there any situation where the San Diego County would abruptly stop an inmate's use of benzodiazepine?

A. There is times where the inmate would come in saying that they were on benzodiazepines, but it was not continued inside the jails.

Q. What circumstances was that?

A. So if it was not able to be verified from an outside provider, because there were people that were using it recreationally. So we would then monitor those individuals to see for signs of withdrawal. And then if there was any signs of withdrawals, then obviously treat them with the Librium, a benzodiazepine taper.

Q. Those people that were on benzodiazepines and you were able to verify the prescription, were those people then -- were those medications abruptly stopped?

A. Yes. Sometimes the psychiatrist thought that this was inappropriate. So then they would be seen by most of the times a psychiatrist, and they would make a clinical decision. And sometimes even the physicians, the jail physicians, or internal medicine, ER, family medicine would state that this was inappropriate and then would stop, ask the patient to be monitored and then wean them off the benzodiazepine.

Q. But it would be weaned off at that point?

A. Sometimes it would be abruptly stopped and look for signs of withdrawal because from when

you stop a benzodiazepine usually the peak of the withdrawal is about 48 to 72 hours. And that's when you start getting the life-threatening symptoms where you could have tremors, elevated blood pressure, elevated heart rate, sweating. So it's pretty significant on how the person's presentation is if they're going down the life-threatening withdrawals. They could have visual hallucinations. So it's very similar to an alcohol withdrawal.

Q. The inmates that are being monitored are they monitored in the separate unit within the San Diego jail?

A. It depends on their clinical condition. If there was a high risk individual, there are sobering cells. So it depends on -- some of these individuals were intoxicated. So they would potentially be drug or intoxicated with alcohol but also report that they were on benzodiazepine. So it really was dependent on what their overall clinical picture was.

Q. Okay. So based on your resume you graduated med school in May of 2007; is that right?

A. Yes.

Q. And then walk me through your job history upon graduation from Syracuse?

A. Sure. I then moved out to San Diego, did an internship at Scripps Mercy Hospital in 2008. Then I did a three-year residency in emergency medicine. So I am a board certified emergency room physician.

After the residency I did a two-year hospital administrative fellowship at UCSD, University of California San Diego. At the same time I also got my MBA at UC Irvine and was working as a emergency room physician as well at both Tri-City as well as University of California San Diego.

After that I became the senior medical officer for Tri-City Medical Center for health care reform. And then less than a year from that point I then became the chief medical officer for the San Diego Sheriff's Department for close to five years.

I left the San Diego Sheriff's Department in June of 2018, did consulting. And then in February of 2019 became the chief medical officer for Alvarado and Paradise Valley Hospitals.

Q. So why is it that you left the San Diego Sheriff's Department?

A. I actually wanted to go back to the hospitals. My fellowship, my training, everything was to go into the hospitals. I really enjoyed the jail and that experience. But I really wanted to one day lead a hospital system. So I felt that was the right time to do it.

Q. So reviewing information, when you left there was no succession plan, right, for the chief medical officer in place to take over for you?

A. They put out a recruitment at the time because I did notify them a few weeks earlier. But I think they were interviewing candidates. And some of the candidates that they interviewed initially was promising, was suppose to come on board but did not.

Q. I'll show you what we marked as 238. This was attached to your disclosure. Of the 19 cases that are listed here, were you an expert in any of these cases?

A. Yes.

(WHEREUPON, THE ABOVE-MENTIONED DOCUMENT WAS MARKED AS EXHIBIT NO. 238 TO THE TESTIMONY OF THE WITNESS AND IS ATTACHED HERETO.)

BY MR. GAHNZ:

Q. Which ones?

A. So Number 6, Number 9, Number 12, Number 13, Number 15, Number 17, 18 and 19.

Q. Okay. Of the eight cases where you have provided expert testimony, how many of those have been on behalf of plaintiff or a claimant?

A. So Number 6, Number 9, and Number 17.

Q. So the other five would be on behalf of the doctor or facility?

A. Yes.

Q. The Howze case Number 6, what was the issue in that case?

A. So that was an individual I believe who had an inflammatory bowel condition, ended up getting a colectomy and then had complicates related to it. But it was over a course I believe a year and-a-half to two years. It was really a chronic care case.

Q. This was somebody that was incarcerated?

A. In a federal facility I believe, yes.

Q. And you were testifying that the care that he received was inadequate?

A. Over the course of a long period of time, yes.

Q. Did that case go to trial?
A. No.
Q. What happened to that case?
A. Settled.
Q. Were you deposed in that case?
A. Yes.
Q. Who was the attorney that hired you in the Howze matter?
A. I don't remember.
Q. Number 9, the Villalon case, what was that case involving?
A. It was an individual for starvation. And this was in Texas. And basically the individual died likelihood of starvation.
Q. Was this a civil rights case, a deliberate indifference?
A. Yes. I believe that was the case.
Q. Is that case still going on?
A. I believe they settled as well.
Q. Who is the attorney that hired you in that matter?
A. I'd have to look to see.
Q. The next one is the Parker versus Christian. Where is that case out of?
A. I believe that was out of Missouri.

Q. Out of Missouri?
A. Yes.
Q. And what was the issue in that case?
A. That was related to an eye complaint.
Q. Is this a federal case or this is a -- I guess it's hard to tell.
A. I don't know if this was federal or not.
Q. Who retained you in that matter?
A. I'd have to look at the name again.
Q. So the cases where you provided expert testimony on behalf of the defendants, did any of those involve jail suicide?
A. No.
Q. Did any of them involve a death in the jail setting?
A. Yes.
Q. Which ones?
A. So Nagy was a liver case, a person who had a significant liver issue. And then Russell had a significant cardiac issue. And I forgot what Gordon was. I'd have to look.
Q. Did any of the cases where you testified as an expert go to trial?
A. Yes. So the ones that say trial testimony, it's there. So Scott versus Clark.

Q. What was the result of Scott versus Clarke?
A. So Scott versus Clarke was a class action lawsuit. And it was I think 20-something inmates against the State of Virginia. It was a female facility. And so I was retained by the defense against essentially a class action. So even though it says Scott versus Clarke, there was a number of individuals involved. So I had to review a number of cases there.
Q. Did that case involve violation of the -- or an alleged violation of a previous settlement agreement?
A. Yes. I believe so.
Q. What was your role in that case?
A. To basically review all the materials related to the systems of care at the facility, to see if the settlement agreement -- how if there was deviations from it. I ended up doing a site visit. So I went there and then did a report related to that, and testified in front of a judge related to the findings.
Q. In any of the cases where you provided testimony as an expert, has your testimony ever been stricken or limited?

A. No.
Q. So the other 11 cases that are listed on Exhibit 23 are cases where you were a defendant; correct?
A. So let's say for one and two with Brummett I was not at the Sheriff's Department at the time. So I was providing just my interpretation -- not interpretation. I was providing testimony and deposition related to what the process was in jail. But it happened prior to my time as chief medical officer.
Q. Okay. So the Brummett case you were not a defendant, but the balance of those cases you were?
A. So the other ones like Torbert, Jones, and Turner, these were pro per cases that I was not a defendant as well. It was the County of San Diego. They were pro per cases. And then I was just again providing testimony related to their accusations.
Q. Okay. I'll show you what we marked as Exhibit 239 and ask you to take a look at that.
MS. SCHNEIDER: Do you have an extra copy?
MR. GAHNZ: I do not. I apologize, I

don't.

(WHEREUPON, THE ABOVE-MENTIONED DOCUMENT WAS MARKED AS EXHIBIT NO. 239 TO THE TESTIMONY OF THE WITNESS AND IS ATTACHED HERETO.)

BY MR. GAHNZ:

Q. Do you recognize these as cases where you have been named as a defendant?

A. So some of these names I have not been served. So I don't know where they were because County counsel of San Diego defends me on all the cases. So my name gets thrown into a lot of lawsuits with, you know, 5,800 inmates and 90,000 a year. So some of these things go through. They notify me. The ones that I know about -- like I've never been -- like United States versus Hernandez, I never heard about that. And it's January 8, 2013. And I wasn't the chief medical officer at that time.

Q. Okay. You can see that one is marked NR?

A. So Thomas this case I was the defendant, but this case settled. Then like the Gilchrist I've never been served. Marchand I never even knew about. So, yeah I'm guessing a number of these things -- Daniels. So County Counsel

usually just notifies me if I'm actually served with anything like they need to defend.

Q. During your time as chief medical officer at San Diego County Sheriff's Department, has the Sheriff's Department settled cases involving claims of deliberate indifference with respect to the medical care?

A. They have not -- in terms of deliberate indifference, no. Basically the one case I would say is Brummett, they did lose at trial in that case. And then it was not deliberately different. It was an indifference claim. And then they paid out related to that settlement, which I think was in the media.

Q. Other than the Brummett case during your time there as a chief medical officer, were there other verdicts involving claims pursuant to 42 USC 1983 civil rights?

A. No. That was the only one I know. Everything else I believe settled or still in litigation.

Q. Okay. In terms of cases that settled involving civil rights claims that involved you during your time there, how many cases were resolved?

A. So I believe the Nunez case was resolved, Number 4, Estate of Nunez. And then the -- the other ones are still ongoing.

Q. Was the Nunez case the one where the County resolved its claims but the private psychiatric services portion of the claim is still moving forward?

A. That might be the case, yes.

Q. Okay. And during your time as the chief medical officer at San Diego County Sheriff's Department, there were situations where the County contracted with private providers; correct?

A. Yes.

Q. And they contracted with psychiatric providers?

A. Yes.

Q. And you were quite critical of the psychiatric provider that was contracted through the County at least for some period of time?

MS. SCHNEIDER: Object to the form of the question. Go ahead.

A. I mean, as part of my quality assurance aspect of it, I think anybody in my position would obviously look for ways of improvement with groups. But basically based on my review of it, I

felt there could be improvement.

BY MR. GAHNZ:

Q. Do you recall stating that they put the County at great risk based on the quality of their care?

MS. SCHNEIDER: Object to the form.

A. Again, as part of quality assurance. Those are quality assurance communications. I believe my role is to improve the system.

BY MR. GAHNZ:

Q. Other than providing presentations at NCCHC, have you done any teaching with respect to correctional health care?

A. In terms of with the staff, yes to the nursing staff while I was at the San Diego County Sheriff's Department. And then even in some of my presentations to certain groups, some of it was more on the educational side.

Q. Do you have any psychiatric training?

A. Just as part of my emergency medicine background.

Q. Other than the PowerPoint presentation, are there other course materials that you have put together with respect to the training that you provided?

A. So those would be all part of the -- with the development of the inmate safety program, there were materials that were developed as part of the policies and procedures as well as some of the training. And that's within the Sheriff's Department.

Q. Do you hold any board certifications?

A. Yes. Emergency medicine. And then also National Commission of Correctional Health Care, I'm a Certified Correctional Health Professional, CCHP. And I also have the physician's designation with that organization.

Q. What does that entail?

A. Basically providing -- you know, being inside the field of correctional health care, essentially doing the continuing medical education credits, and then taking a test to see that you're certified. And the test is related to the standards of correctional health care.

Q. Okay. So other than the eight cases that are listed, are you still doing consulting work?

A. Yes.

Q. What percentage of your time is spent on doing consulting work?

A. Probably 10 percent.

Q. And what type of consulting work other than the jail civil rights litigation consulting are you doing?

A. That's pretty much it. Because I'm the chief medical officer for the two hospitals that occupies a lot of my time.

Q. I'm sorry?

A. I'm the chief medical officer of the hospitals, so that occupies much of my time.

Q. That's why I was asking. It seem like you had a pretty full plate. Do you work through a service?

A. No.

Q. Have you ever worked with -- I think I may have asked this. But have you ever worked with Maria's firm before?

A. No.

Q. What about any of the firms in this case?

A. I don't believe so.

Q. Okay. Do you have a copy of your report handy? If not I do. I'll show you what we marked as Exhibit 240. Is this a copy of the report that you authored in this matter?

A. Yes.

(WHEREUPON, THE ABOVE-MENTIONED DOCUMENT WAS MARKED AS EXHIBIT NO. 240 TO THE TESTIMONY OF THE WITNESS AND IS ATTACHED HERETO.)

BY MR. GAHNZ:

Q. The first three or four pages deal with your background; correct?

A. Yes.

Q. And so then at page 5 you list the items that you reviewed; is that correct?

A. Yes.

Q. That's everything that you have seen in this case or have you seen -- you indicated that you saw Dr. Folks' report subsequent; correct?

A. And then there's additional materials and supplemental I reviewed.

Q. Those are in bold in the supplemental report; correct?

A. Yes.

Q. That one we marked as Exhibit 241; correct?

A. Yes.

(WHEREUPON, THE ABOVE-MENTIONED DOCUMENT WAS MARKED AS EXHIBIT NO. 241 TO THE TESTIMONY OF THE WITNESS AND IS ATTACHED HERETO.)

BY MR. GAHNZ:

Q. All right. If we go to the supplemental Exhibit 241, there's a listing of 29 items; correct?

A. Yes.

Q. And this is the 29 items that you reviewed in preparation for your testimony?

A. Yes.

Q. And you already testified that you did look at the NCCHC standards?

A. Yes. And that's listed as Number 2.

Q. That was the standards that were in place in 2016; correct?

A. 2014.

Q. They were promulgated in 2014, and they were still the standards in 2016?

A. Yes.

Q. There's been changes to them subsequent?

A. In 2018 a new book.

Q. Have you been provided with everything that you have asked for?

A. Yes.

Q. Is there any additional information that you would have wanted to review that you did not receive?

A. No.

Q. Okay. Other than the NCCHC, did you consult with any books, articles or other learned treatises?

A. Just from my knowledge base on the benzodiazepines, Gabapentin, and other things that were present from a clinical standpoint.

Q. So these are things that you had previous knowledge of based on reading that you had done?

A. Based on previous reading, based on working in the emergency department, and my other clinical experience.

Q. Okay. Is there any particular source that you would say this is what I was trained using and this is why I know what I know with respect to --

A. So I typically use UpToDate, which essentially gives you a synopsis and summary of all of the up to date literature and the studies related to various clinical topics. So I do have a subscription for that. So I do research based on that.

Q. Okay. The UpToDate is something that you use to keep yourself current and in your daily

practice of medicine; correct?

A. Yes.

Q. Did you discuss any of the issues related to this case with any of your colleagues?

A. No.

Q. Did you speak with any of Ms. Freiwald's treating providers?

A. No.

Q. Did you speak with any witnesses?

A. No.

Q. Did you visit the jail?

A. No.

Q. Did you do any sort of a virtual tour?

A. No.

Q. At pages 5 and 6 of your report --

A. The regular report or the supplemental?

Q. It looks like you did it twice. So at pages 2 and 3 of your supplement, and 5 and 6 of your regular. My first question is was there anything that was added to the summary of document review in your supplement or did you just copy and paste it?

A. That was copy and paste.

Q. Let's deal with your initial report. You went through and tell me what the purpose was

of the summary of document review?

A. So it was just to provide a timeline of the care that Ms. Freiwald received. Also, for the purpose of deposition as well to basically make sure the dates and everything else are correct, and just to highlight points related to what the opinions were based on.

Q. So is it a fair statement that these are to you the important events in the chronology of this case?

A. Yes.

Q. Okay. The information that is contained in your summary, where did you get the information from?

A. From the medical records. So from the records and materials reviewed.

Q. And was this information that you gleaned as you were reviewing the records or was this information that this timeline provided to you by somebody else?

A. No. I write all my own reports and all my own summary myself.

Q. Okay. So the first thing that you have in here in your summary of document review is the February 8, 2016 suicide attempt; correct?

A. Yes.

Q. Why is that significant to your analysis in this matter?

A. So the crux of this case comes down to based on the complaint is that the Gabapentin and not being on the Klonopin was a trigger for Ms. Freiwald attempting suicide. Why I think this is extremely important is she was on Klonopin and Gabapentin on February 2016. And she overdoses on 90 pills of Klonopin at that time, cuts her wrist and then uses her car as a weapon to try to hurt herself and potentially kill other people. I think that is extremely important because those are the -- based on the complaint the accusation is that she was stable on those medications. She wasn't stable on it months earlier.

And I think again based on my supplemental report that it's reckless of the psychiatrist to re-prescribe the Klonopin to begin with. And I don't believe she should have been on it if you overdose on 90 pills of that in just a few months earlier.

Q. So in looking at your document review, did you have any of Ms. Freiwald's records?

A. Yes. So I guess the Prevea Health

Records, the Brown Community Treatment Center, the St. Vincent, the Belin. So, yeah what is in there.

Q. My question was inartfully worded. Let me try it a different way. Did you have records from Ms. Freiwald prior to February of 2016 that you reviewed?

A. If it was not based on these records, I don't believe so.

Q. Do you know the dosage of Clonazepam that Ms. Freiwald was on as of February 8, 2016?

A. I would have to look at the records again to see what the dosage was. I don't recall it off the top of my head.

Q. Do you know what the dosage of Gabapentin?

A. Again, I'd have to -- I'm thinking it's around six -- I don't know if it was 600 milligrams. But I'd again have to look at the records to verify.

Q. Do you know whether Ms. Freiwald was receiving any sort of counseling as of February 8, 2016 and before?

A. I know that she received counseling afterward. I'd have to look. I don't know if she

was receiving it before.

Q. Do you know if Ms. Freiwald had ever been treated for PTSD symptoms prior to February 8, 2016?

A. I believe she was. But, again, I'd have to look at the records.

Q. Would any of those make any difference to the opinions that you have in this case?

A. No.

MS. SCHNEIDER: Object to the form.

BY MR. GAHNZ:

Q. The 90 tablets of Clonazepam, do you know how many milligrams that was per tablet?

A. I don't know if it was the one --

Q. Were they half milligram tablets? Were they two milligram tablets? Do you know?

A. It was in the range of -- around that range. But I'd have to look at the records to see what the exact dosage was.

Q. Do you have any of that information here with you today?

A. No.

Q. So the next item that you have is the commitment to the Nicolet Psych Center at Brown County; correct?

A. Yes.

Q. And what was significant to that event to your opinions?

A. It actually provided based on her seeing the mental health staff there why she tried to commit suicide. And it was related to the relationship issues and the loss of business. So those were what they determined was the triggers.

Q. Then was there anything else that was significant to your opinions that occurred between February 12th and March 10th?

A. That she was referred to basically a psychiatrist, a psychiatric nurse practitioner, and to mental health. So that referral process took place.

Q. Then you indicate that she was seen by Dawn Vardia and Dr. Sheets; correct?

A. Yes. I know she was also seen by Nurse Practitioner Paige during that time too.

Q. You note that at that point she was being prescribed Gabapentin, Clonazepam, aspirin, Diclofenac, fluoxetine, Lisinopril-HCTZ, multivitamins and Ambien; correct?

A. Yes.

Q. It's your opinion that Dr. Sheets

committed malpractice by putting Ms. Freiwald back on Clonazepam?

MS. SCHNEIDER: Object to the form.

A. Yes. Based on again on my supplemental report I think it's equivalent to someone who tries to commit suicide by firearms and then allowing them to have access to firearms in a very short period of time.

BY MR. GAHNZ:

Q. Did Dr. Sheets commit malpractice in your opinion in any other way?

A. No.

Q. You list as her past medical history that she had anxiety; correct?

A. Yes.

Q. How long had she been suffering anxiety?

A. It was for many years.

Q. And prior to February 9, 2016 how long had she been on Clonazepam?

A. I'd have to look through the records. But I believe it was a significant period of time.

Q. She was also diagnosed with a major depressive disorder; is that correct?

A. Yes.

Q. In your opinion did she carry -- was she

still suffering from anxiety and major depressive disorder as of October 27, 2016 when she checked into the Brown County Jail?

A. Yes.

Q. She was also diagnosed in March of 2016 with post-traumatic stress disorder; correct?

A. Yes.

Q. Was she still suffering from post-traumatic stress disorder when she checked into the jail on October 27, 2016?

A. Yes.

Q. Was she actively treating for anxiety as of October 27, 2016?

A. Yes.

Q. Was she actively treating for major depressive disorder as of October 27, 2016?

A. Yes.

Q. And was she actively treating for post-traumatic stress disorder as of October 27, 2016?

A. Yes.

Q. Was she receiving treatment beyond medication treatment for those conditions as of October 27, 2016?

A. She was getting counseling throughout those months.

MR. GAHNZ: Why don't we take a short break.

(WHEREUPON, A BREAK WAS TAKEN AND THE PROCEEDINGS CONTINUED AS FOLLOWS:)

BY MR. GAHNZ:

Q. As we were going through your timeline and in terms of the decision of Dr. Sheets to restart the Clonazepam, what information did you review before coming to your opinion that that was reckless?

MS. SCHNEIDER: Object to the form.

A. It was related to the overdose attempt of 90 pills of Clonazepam, and then her essentially being at the Nicolet Psych Center, what the reasons were. Based on her mental health records it was pretty clear that if a life trigger was going to happen, that she would utilize things around her to hurt herself. And so to basically put her on a medication that she could overdose again if a similar event happened in the future, I thought was again reckless.

BY MR. GAHNZ:

Q. So what is the legal dose of Clonazepam?

A. It is dependent on the person. It is to the point where you get respiratory depression,

and essentially you could aspirate, which is essentially the gastric contents going into your lungs, or you could just stop breathing. So it could be different for different people.

Q. So on an annual basis how many people die from Clonazepam overdose?

A. I would have to do a literature search to know that. But in many overdoses benzodiazepine is mixed with alcohol and other types of drugs. So it's typically a mixed picture.

Q. So did you review Dr. Sheets' medical records?

A. Specifically for the ones that were listed in this materials. I did see his -- that he did see her. And, so yes for those records I did review.

Q. And in review of those records were you able to determine what information he had, he being Dr. Sheets, when he made his determination to continue the Clonazepam for Ms. Freiwald?

A. So he stated that I believe that due to her anxiety that he restarted the Clonazepam related to the anxiety.

Q. Do you know what other information he

had in coming to the determination to restart the Clonazepam?

A. I do not know.

Q. So whether he had seen 20 years worth of previous records to make the determination is not something that you know one way or the other?

A. Well, I would think that if he knew, and I think he did know that she had a serious suicide attempt overdosing on 90 pills, that a similar event could happen in the future, and then she would have access to those same medications under maybe unsupervised conditions, the same issue would have happened. So, again, I think he's putting his own medical license at risk there too for prescribing something that clearly could be used to hurt herself in the future.

Q. I appreciate that. But my question was slightly different. Do you know whether or not he reviewed Ms. Freiwald's previous medical record in coming to his conclusions to restart the Clonazepam?

A. I don't know specifically. I would assume so.

Q. Dr. Sheets did, in fact, meet with Ms. Freiwald; correct?

A. Yes.
Q. How many times?
A. I believe twice.
Q. For how long?
A. I didn't look at what the time notes were.
Q. Which other of Ms. Freiwald's doctors did Dr. Sheets talk to before he made the determination to restart the Clonazepam?
A. I don't remember.
Q. Are those things that you considered in coming to your opinions?
A. So, again, it would be -- to me this is the equivalent of someone having serious attempt by -- let's say another like opiate overdose, the person has a history of opiate addiction, and then essentially getting restarted on opiates. So to me in this type of situation the Clonazepam clearly is not, you know, helping.
In terms of her anxiety there are alternatives that could be used. To put her on a medication that she could potentially harm herself in a lethal way again I think -- he should have tried something different for the anxiety versus the Clonazepam when it clearly led to a serious

suicide attempt.
Q. So do you know prior to February 2016 the last time that Ms. Freiwald had refilled her Clonazepam prescription?
A. I'd have to look at the records to see.
Q. Do you know whether or not prior to February 8, 2016 she had taken Clonazepam in the last week to two weeks?
A. Again, I'd have to look at the records to see the compliance part of it. I wouldn't know.
Q. As you were coming to your opinions, you didn't note that in the significant event timeline; correct?
A. Because it's not relevant. Again, the relevant part where it starts off is the serious suicide attempt and what was the methods used, which is the 90 pills of overdose, the cutting of the wrist, and then using the car to try to hurt herself or others. So that I feel was the focal point because that is a person that is extremely determined to want to basically kill themselves and using multiple methods.
So essentially what this clearly shows is she will use whatever method possible in a life

trigger event to basically kill herself. And so that is why I thought this was extremely important to note.
Q. Would it make any difference to you if the situation was that she had stopped taking her Clonazepam a week before the February 8, 2016 suicide attempt?
MS. SCHNEIDER: Object to the form. Assumes facts not in evidence. Go ahead.
MR. MCGAVER: Join.
A. So if that was the case I would say that it is even more reckless to put her back on the Clonazepam knowing that any time she stops it, she would basically try to harm herself. So it almost reinforces my -- that Dr. Sheets I don't believe he should have put her back on the Clonazepam, and he should have done an alternative non-addicting substance that doesn't have both the life-threatening withdrawals as well as the propensity for this event to happen.
BY MR. GAHNZ:
Q. Did you come to the conclusion that Ms. Freiwald was addicted to Clonazepam?
A. Anyone who is on Clonazepam for that long period of time clearly develops a tolerance

and clearly needs that medication, because based on again Dr. Sheets re-prescribing it for anxiety, there is a level I believe in this situation of her being tolerant of the medication that she needs it. So whether you call it addiction or dependence, I do believe there was some dependence on Clonazepam for her.
Q. Okay. At page 7 your statement that there is no evidence that Dr. Fatoki fell below the standard of care or provided anything other than appropriate care related to the medical care and medication management of Ms. Freiwald.
A. Yes.
Q. So the question that I have is what information did Dr. Fatoki have at the time that he made the determination to discontinue the Gabapentin and the Clonazepam, what did he know about Ms. Freiwald?
A. So he knew she was on those medications coming into the jail. I do not believe he knew about the suicide attempt.
Q. Okay. Did he know any of the mental health diagnoses that Ms. Freiwald carried when she came into the jail?
A. I believe -- I don't know -- based on

her being prescribed these medications, I would assume that he would definitely know that there were indications for why these medications were prescribed. So he would have a knowledge in that aspect of what potential past medical history is. Similar to if somebody came to me and said they were on the Lisinopril, I would assume this person has a history of hypertension and is being treated for it whether I ask that person or not. So in terms of gleaning it, I think he would be able to.

Q. Sure. But there's a difference, isn't there, between a drug like Lisinopril and a drug like Gabapentin in terms of off label uses; right?

A. Yes.

Q. Gabapentin is Neurontin?

A. Yes.

Q. Neurontin has a number of label uses and a number of off label uses; correct?

A. Yes.

Q. So it's a little bit different in terms of being able to glean why someone is on Gabapentin than it is why somebody is on Lisinopril?

A. But based on the totality of all the medications she is prescribed, you can get a

number of the diagnosis.

Q. You read Dr. Fatoki's testimony; right?

A. Yes.

Q. And so you know that his testimony it was essentially that he didn't have any knowledge or information as to Ms. Freiwald's past medical history?

MS. SCHNEIDER: Object to the form. It misstates his testimony. But go ahead.

A. The past mental health of the suicide attempt, yes.

BY MR. GAHNZ:

Q. You're also aware that Dr. Fatoki testified that he was unclear as to why Ms. Freiwald was on Gabapentin?

A. Yes.

Q. And that he was unclear as to why she was on Clonazepam?

A. Yes.

Q. In fact, he testified that he did not have any information as to why Ms. Freiwald was prescribed Gabapentin or Clonazepam?

A. And that is why I think he requested a release of information records for the Gabapentin.

Q. That's something that would take several

weeks to get the answer to that question; correct?

MS. SCHNEIDER: Object to the form.

A. It depends on the jail. Some jails can get it in a much shorter period of time.

BY MR. GAHNZ:

Q. You're aware that Dr. Fatoki testified that the process of getting previous records this process sometimes can take many days?

A. Yes.

Q. That when Dr. Fatoki made the decision to stop the Gabapentin and the Clonazepam, he had not communicated in any way with Ms. Freiwald?

A. Not with Ms. Freiwald, no.

Q. Or any of her doctors?

A. Not with her physicians, no.

Q. Or her nurses?

A. I believe he did state for her to be monitored for withdrawal for the Clonazepam.

Q. What's your understanding of who was to be doing the monitoring for the Clonazepam withdrawal?

A. The nursing staff.

Q. Was that to be done in a protocol similar to what you had described with the San Diego County?

A. I don't believe it was based on that protocol. It was based on to me more visual observation. Again, when you withdraw from benzodiazepines like Clonazepam, you will get tremors, you will get shakes. It's very, very readily apparent that the person is going through withdrawals. So it's obvious to even a correctional officer or to a nursing staff the person is going through a withdrawal.

Q. Is it your understanding though that Dr. Fatoki was expecting the nursing staff to monitor Ms. Freiwald's condition?

MS. SCHNEIDER: Object to the form.

A. For signs of withdrawal, yes.

BY MR. GAHNZ:

Q. Thank you. Let me restate the question. Was it your understanding that Dr. Fatoki was expecting that the nurses would be monitoring Ms. Freiwald for signs of benzodiazepine withdrawal?

A. Yes.

MS. SCHNEIDER: Object to the form.

BY MR. GAHNZ:

Q. At the time of her incarceration at the Brown County Jail, what was the dosage of

Clonazepam that Ms. Freiwald was on?
A. I believe it was 1.5 milligrams. I'd have to look to verify.
Q. 1.5 milligrams per day?
A. I'd have to look to verify that dose. If you have it --
Q. I'm showing you what was previously marked as Exhibit 24. Have you seen that?
A. Yes.
Q. As part of the documents that you reviewed?
A. Yes.
Q. That indicates that at least based on Exhibit 24 that she was on Clonazepam 1 milligram plus an additional .5 milligrams as needed?
A. Yes.
Q. So she could be taking one milligram up to three or four milligrams a day?
A. Yes.
Q. So kind of back up to your statement. So Dr. Fatoki at the point in time he made the decision to take Ms. Freiwald off the Gabapentin and the Clonazepam had the information only that she was on these medications?
A. Yes.

Q. And that she was in jail?
A. Yes.
Q. Was there any other information that he had about Ms. Freiwald at the time that he made those decisions with respect to Gabapentin and Clonazepam?
A. So, in speaking with the nursing staff I'm assuming that he had a more in-depth conversation about how she was looking, if she was undergoing issues or withdrawal or other aspects because normally any provider would ask that type of information for that. So I assume he and the nurse had some communication related to her appearance and how she was presenting.
Q. Okay. That's an assumption on your part?
A. Yes.
Q. Is there any written record that would show that there was some discussion between Dr. Fatoki and any nurse as to how Ms. Freiwald was presenting?
A. It was just the fact that they had that communication, so I think that that phone call happened. But I don't know what the contents of the phone call were.

Q. What is your understanding as to the contact between any nurse and Ruth Freiwald? And I want to be very precise in terms of the time frame. Between the time that Ms. Freiwald got to jail and the time that there was the phone call between the nurse and Dr. Fatoki?
A. So I think it was based on them responding back to her related to the inmate request forms.
Q. Is it your understanding that a nurse had face-to-face contact with Ms. Freiwald in response to the inmate request form?
A. Based on the documentation, I don't know how that was relayed back to her, if it was face-to-face or an alternative communication plan. But it's documented that they addressed the inmate with the form itself. So I assume there was some potential communication.
Q. Okay. Do you know based on your review of the records in this case whether or not a registered nurse had face-to-face contact with Ruth Freiwald at any time that she was at the Brown County Jail from October 27th to November 2nd?
A. I have to assume throughout the course

of this that there were probably interactions. But I did not see it in the documentation.
Q. Would it make any difference if there were not any face-to-face interactions between Ms. Freiwald and a registered nurse during the time that she was at the Brown County Jail?
MS. SCHNEIDER: Object to the form.
A. No. Unless she was in acute medical distress. But based on again all the records, there is no evidence of withdrawal or acute distress while she was incarcerated.
BY MR. GAHNZ:
Q. Okay. What records are you relying on for your conclusion that there was no evidence of acute withdrawal?
A. Based on a number of things, the depositions as well as the medical records. So the depositions of some of the correctional officers, some of the staff that -- majority of it is also during the time she goes to the HUBER or the work release program that there was no evidence of distress or withdrawal at that time that they allowed her to go outside of the jail.
Q. So within the supplemental report, I just wanted to double check in terms of -- so you

had the opportunity to look at the deposition of Debora Gryboski; correct?

A. Correct.

Q. Do you recall Debora Gryboski's testimony about Ms. Freiwald at NWTC?

A. Yes.

Q. And she was distressed when she was at NWTC?

MS. SCHNEIDER: Object to the form.

A. So not in medical distress, but there were I guess other factors that she was complaining about.

BY MR. GAHNZ:

Q. Was she complaining about not getting her medications?

A. She was complaining about not getting her medications and I believe also that the TV was too loud, and I think the window and the lighting. There was a number of issues that were not related to an actual medical issue.

Q. Okay. You also had the chance to see Julie Chapman's deposition; correct?

A. Yes.

Q. She was testifying about her observations of Ms. Freiwald at NWTC?

A. Yes.

Q. Did you see any testimony or any records that there was any interaction between anybody from the Brown County Jail staff and Ms. Freiwald?

A. I mean, there were -- there definitely was interaction especially on the day she goes to the HUBER program, because there were correctional officers that were involved there. And I think -- I forgot which deposition it was. I think there was no -- again, in the issue of acute medical distress or withdrawal that no one observed that she was having any kind of those types of issues.

Q. There's no report one way or another; correct?

A. There's no report, no.

Q. You also saw the deposition of Matthew Fett, her son; correct?

A. Yes.

Q. He described what his mother's condition was?

A. Yes.

Q. In terms of Dr. Fatoki's decision to discontinue the medications of Gabapentin, is it your understanding that the jail would dispense those medications as stated on the dosage provided

by the provider?

MS. SCHNEIDER: Object to the form of the question.

BY MR. GAHNZ:

Q. As opposed to giving the inmate the entire bottle of pills?

A. The nurse would essentially administer each pill.

Q. And so the way that I understand the process is each day the provider would come by with the medication packaged in a particular envelope and say this is your medication for the day?

A. For those medications, yes. In certain jails there's also a Keep On Person program where they can actually get like Motrin. They can get a packet of -- a number of them. So in those situations they could get a number of pills. But outside of the KOP or Keep On Person program, everything else would be administered usually by a nurse to the inmate.

Q. The import of the question is your review of the records indicate that Brown County had security policies in place to make sure that medications were being dispensed appropriately?

A. Yes.

Q. Okay. And so with respect to Gabapentin, what would have been the harm to Ms. Freiwald had Dr. Fatoki continued that medication until such time as he got the medical records to determine why she was on it?

MS. SCHNEIDER: Object to the form. Incomplete hypothetical. But go ahead.

A. So Gabapentin is one of the most highly abused medications in a correctional facility. It's number one. I think number two is Ultram and Tramadol back in 2016. So it is significant abuse potential for the inmate. The other thing is they're significant in many jail victimization. Inmates get beat up on those medications or they sell and trade and hoard them. Overdose potential is very, very high where they take a number of the pills and they try to cheek it. So there's a lot of dangers especially with those two medications specifically.

BY MR. GAHNZ:

Q. Was there any indication that the Brown County Jail medication dispensing policies and methods were such that hoarding and cheeking medications was an issue?

A. It's an issue in any jail or facility.
Q. So other than the security concern that you just expressed, were there other potential harms to continuing the Gabapentin?
A. Yes. If she hoards the medication and then tries to overdose on it, that could be potentially creating a issue where she could have self-harm while in the jail.
Q. Now given that Ms. Freiwald was on the HUBER work release, does that mitigate that concern in any way?
MS. SCHNEIDER: Object to the form. Incomplete hypothetical.
A. So again, I think when you look at the records, the other aspect that is kind of glossed over here is she doesn't bring in the medications when she reports to the jail of what she was supposed to be on and everything else. And, again, I think the trigger here was the fact that I think she expected to be out in a day or so, but had to be there for a longer period of time. So I think that's what triggered all of these events that was irrespective of the medication.
BY MR. GAHNZ:
Q. I don't want to gloss over anything.

The medications were brought in the next morning; correct?
A. Yes.
Q. Had she brought them in on the 27th, what difference, if any, would that have made in Dr. Fatoki's decision making?
MS. SCHNEIDER: Object to the form. Incomplete hypothetical.
MR. MCGAVER: Join.
A. So in terms of the Gabapentin and having the outside records, if all of those records were brought at the point of the intake, he would have just made a decision based on the available records. So I would think that if the person has the ability and they know they're checking into the jail in a almost planned type of way, that they would provide all of the available information at that point. If it's not there, then he has to then make the clinical judgment which in his situation he basically asked for prior records to verify that this person was on Gabapentin.
BY MR. GAHNZ:
Q. So it's your expectation that Ms. Freiwald should have brought in her medical

records and her medications on the 27th when she was ordered to jail?
MS. SCHNEIDER: Misstates his testimony. But go ahead.
A. So in this type of situation I think in a planned incarceration episode, which this look like it was to ask someone to be reporting at a specific time, that with her history and everything else like that, that she would bring in the records of what she was prescribed, and not just specific to these two, but to the blood pressure and other medications.
BY MR. GAHNZ:
Q. Do you know whether or not Ms. Freiwald had any knowledge as to whether or not there was going to be a doctor, a jail doctor reviewing her medications?
A. I do not know.
Q. You are aware, however, that she was ordered by the court to take all of her prescribed medications?
MS. SCHNEIDER: Object to the form.
A. Yes.
BY MR. GAHNZ:
Q. And Dr. Fatoki was not aware at the time

that he discontinued those medications of this court order; correct?
A. So I've been in very similar situations. The court order about continuing medication does not substitute clinical judgment. The doctor is the one prescribing the medication. So it's under his license. So unlike what -- again, this is where the supplemental report goes into that. But it's not the expectation that anything prescribed on the outside would immediately be continued on the inside by that provider. That provider would just then be a technician.
And he has to exercise independent clinical judgment and essentially prescribe this medication almost as new when they're coming into the jail, because different clinical factors could be in play and you're dealing with a very different population of situation. So as a result it's under his license and his clinical judgment on what he's going to provide. And he has a right to not prescribe medications too.
Q. And I appreciate that. My question was a little bit different though. Was Dr. Fatoki aware that the court had ordered Ms. Freiwald to take all of her prescribed medications at the time

he made the decision to discontinue the Gabapentin and the Clonazepam?

MS. SCHNEIDER: Objection. Asked and answer.

A. I don't believe so.

BY MR. GAHNZ:

Q. Is the standard of care different if a person is going to be in jail than for a person that is not going to be in jail?

MS. SCHNEIDER: Object to the form.

A. So the standard is not different. But there are different factors that would make certain medications potentially not viable inside a correctional facility versus on the outside.

BY MR. GAHNZ:

Q. What is the number one symptom of Clonazepam withdrawal?

A. Number one symptom?

Q. Yes.

A. Depending on the various stages it could cause evaluated heart rate. It can cause sweating or diaphoresis. It can cause evaluated blood pressure. It can cause tremors. And then in a really bad case it could start causing visual hallucinations.

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Q. What about rebound anxiety?

A. So anxiety would be part of that constellation of symptoms.

Q. In fact, isn't rebound anxiety the number one symptom of withdrawal from benzodiazepine?

MS. SCHNEIDER: Object to the form.

A. So typically that is accompanied by elevated blood pressure, sweating, elevated heart rate. So that would be constellation of -- those physical symptoms would also be present with the increased anxiety.

BY MR. GAHNZ:

Q. Was Ms. Freiwald complaining of any of these symptoms while she was incarcerated?

A. Based on the records she did say that she had anxiety.

Q. And what, if anything, was done in response to that?

A. So I don't believe -- specifically for the anxiety she was not re-prescribed the Clonazepam. But I believe she was prescribed Prozac.

Q. So when somebody comes into jail, would you agree with me, that that is an anxiety

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inducing event?

A. It's a major life trigger. Yes.

Q. And if somebody comes into jail and they have a history of anxiety, would that be something that the treating physician would want to take into account in his or her medical decisions?

MS. SCHNEIDER: Object to the form.

A. So I don't think it would -- again, I do not see a causal link here between the anxiety and the suicidal ideation, or suicide attempt. Everybody experiences anxiety and obviously has different coping mechanisms. Even with many history of anxiety there's thousands of individuals that come in with anxiety on anxiety medications that are abruptly stopped but they don't go on to do suicide attempts. So I think this situation is very, very different in terms of her coping mechanism.

MS. SCHNEIDER: Would you read the question back please.

(RECORD READ BY THE COURT REPORTER.)

A. Yes.

BY MR. GAHNZ:

Q. What about an inmate that has severe depression?

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A. Yes.

Q. And what about an inmate who had attempted suicide within six months of her incarceration?

MS. SCHNEIDER: Object to the form.

A. Yes.

BY MR. GAHNZ:

Q. What about within eight months of her incarceration?

MS. SCHNEIDER: Object to the form.

A. Again, the more information the better. So if that information is available, obviously they would have to take that into account.

BY MR. GAHNZ:

Q. Is there any literature that supports the proposition that it is medically acceptable to stop somebody's benzodiazepine cold turkey?

MS. SCHNEIDER: Object to the form.

A. There's no literature that states that.

BY MR. GAHNZ:

Q. In fact, all the literature says if you're going to take somebody off of a benzodiazepine it should be done on a tapered basis; correct?

A. Or to look for signs of withdrawal.

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Q. Under a close monitoring situation; correct?
A. Under a monitored situation, yes.
Q. And the monitoring should be done every 15 minutes?
MS. SCHNEIDER: Object to the form.
A. So the time frames are different depending on the literature. But there are standard time intervals, yes.
BY MR. GAHNZ:
Q. What is the maximum allowable interval of monitoring?
MS. SCHNEIDER: Object to the form. It's vague. Overly broad.
MR. MCGAVER: Join.
A. I have seen protocols that you can go eight to twelve hours.
BY MR. GAHNZ:
Q. It's your understanding that Ms. Freiwald was out in the community for how long on a daily basis on the HUBER release?
A. It was just to participate in those classes. So I'm guessing a few hours.
Q. But you don't know -- she could have been out as much as 12 to 14 hours as far as you

know?
A. I didn't see the clock in, clock out systems.
Q. It's also your opinion that Ms. Freiwald's mental status was not well controlled at the time she entered into the jail. Is that a fair summation of your opinion?
A. Yes.
Q. Do you know whether Dr. Fatoki was aware that Ms. Freiwald was going to be sent to the HUBER Center upon her incarceration?
A. I don't believe so.
Q. I didn't see it in the list but I'm going to ask you, did you look at the contract between CCS and Brown County?
A. No.
Q. Would you expect that Dr. Fatoki as the medical director of the region would know of the terms of the contract between Brown County and CCS?
MS. SCHNEIDER: Object to the form.
A. I would not believe that he would be knowledgeable. Usually the medical directors are not. Unless he needed to know for a particular reason, they're usually not given those cross.

BY MR. GAHNZ:
Q. In review of any of the records or documents that you saw in this case, did you note that CCS's contract excluded HUBER inmates?
A. I did not review the contract.
Q. You read testimony though?
A. Yes.
Q. And you have seen there's been a bunch of questions that have been asked about the contract. So that's my question, did you see that in any of the information that you reviewed?
A. Can you repeat that?
Q. Sure. In any of the information that you reviewed, did you see that the contract between CCS and Brown County excluded HUBER inmates?
A. I don't recall.
Q. Okay. Would it make any difference if CCS excluded HUBER inmates from the contract as far as medical care to be provided?
MS. SCHNEIDER: Object to the form.
MR. MCGAVER: Join the objection.
A. Again, I don't know like what -- I'm actually kind of confused.
BY MR. GAHNZ:

Q. Let's assume for a minute that there is a contract between CCS and Brown County.
A. Yes.
Q. Okay. And within that contract it specifically says CCS will not be providing medical care to HUBER inmates.
A. Yes.
Q. Okay. Are you with me so far?
A. Yes.
Q. Assuming those two things to be true, does that make any difference to you in terms of your opinions?
MS. SCHNEIDER: Object to the form. Incomplete hypothetical.
MR. MCGAVER: Join.
A. So is this when she's in the HUBER program or is this while she's in the jail?
BY MR. GAHNZ:
Q. Assume for the sake of this question that the contract says that HUBER inmates are excluded from the contract as far as medical care being provided by CCS.
A. So, I mean, I'm assuming it's when they're outside of the jail. So if it's for both, I mean -- again, I'd have to see the contract to

see.

Q. That's just not something you have reviewed?

A. No.

Q. So you're not prepared to testify one way or another?

A. I'm prepared to testify based on, again, what I have read in the report that when Ms. Freiwald leaves the jail, the responsibility of all of the actions, the suicide prevention and all of those things is not the responsibility of the jail, clinical, or Dr. Fatoki at that point. If she makes an impulsive decision while she's unsupervised outside of it, that is not the responsibility of the jail. That is my opinion.

Q. What's that based on?

A. It's based on any jurisdiction of any correctional facility. Once a person is released, that person -- if somebody was released out of custody at 2:00 a.m. and they walked out of like the jail right behind us, and this has happened and they collapsed like two or three minutes later or something else happens, technically -- obviously the deputies are there or somebody is there, they could call 911. But they're not the

responsibility of the facility. The facility's responsibility is within the jurisdiction of the actual inside of the facility. So once they're outside of it and they're unsupervised, they would be like any normal person like me or you if something was to happen to us here.

Q. So is it your understanding that Ms. Freiwald was released from custody to attend the work and school?

MR. MCGAVER: Object to the form.

MS. SCHNEIDER: Join.

A. So she was unsupervised. So, in essence, for the period of time that she's physically outside of the walls, she is out of custody in my opinion. And I will say that even in San Diego jails there are individuals who report to their incarceration just for weekends, and then they work Monday through Friday. They report on Friday, and they leave on I think Sunday or Monday morning. During the time they're in the jail, the jail is fully responsible for things that happen inside the jail.

But outside of that jail during the Monday through Friday, if something was to happen, obviously the jail is not responsible and the

clinical staff is not because the person is not being escorted with a guard and being said that this person is under custody with ankle bracelets and everything else like that. So based on this, that's why I think this case is very unique that she commits the suicide attempt while she's unsupervised outside of custody in my opinion.

BY MR. GAHNZ:

Q. If she still subject to the jail rules?

MS. SCHNEIDER: Object to the form.

MR. MCGAVER: Join.

A. So I would assume in this type of situation there would be consequences if she didn't follow the rules, like if she tried to escape and went to a different state. She could have the power to do all of those things and never show back up to the jail. So there would be consequences. But, in essence, she's out of custody because no officer is running after her if she, let's say, decides to bolt and tries to not report back.

BY MR. GAHNZ:

Q. Okay. Is it your understanding that Ms. Freiwald is not allowed to take her prescribed medications -- strike the question and start over.

Under the jail rules would Ms. Freiwald have been allowed to take Clonazepam while she was at NWTC for class?

A. Again, I think it's based on the clinical decision of the provider. I'd have to look to see if they disallowed like benzodiazepines to be as part of the program.

Q. While Ms. Freiwald is at class on the work release, you're saying that she's not under the supervision of the clinical staff; fair enough?

A. Yes.

Q. So would that mean that her medical care would revert to her community provider?

MS. SCHNEIDER: Object to the form.

MR. MCGAVER: Join.

A. It is very well possible at that point.

BY MR. GAHNZ:

Q. Okay. And so as far as your opinion is is that Dr. Fatoki was well within his rights to discontinue the Gabapentin and the Clonazepam while she was within the jail facility, but then Ms. Freiwald was free to take those outside of the jail facility while she was on work release?

MS. SCHNEIDER: Object to the form.

Incomplete hypothetical.
MR. MCGAVER: Join the objection.
A. So if she was followed by her outpatient doctors, once she's out there in the classroom setting, I mean, that is -- if she has outpatient providers, they could provide certain types of care for her, I do believe that. But Dr. Fatoki is not responsible while she's physically outside.
BY MR. GAHNZ:
Q. Okay. Do you have your report handy?
A. Yes.
Q. At page 7 towards the bottom you indicate that it should be noted that a suicide screening questionnaire and booking observation are completed on October 27, 2016 on Ms. Freiwald and no assessment was made where she posed an immediate suicide risk; right?
A. Yes.
Q. I want to talk about that a little bit.
A. Okay.
Q. The suicide screening showed that she posed a suicide potential; correct?
MS. SCHNEIDER: Object to the form.
MR. MCGAVER: Join the objection. It misstates testimony.

A. I think it says that she potentially had a prior attempt. But she was actively denying any suicide ideations.
BY MR. GAHNZ:
Q. My question was different. The result of the suicide screening indicated that Ms. Freiwald was a potential suicide risk; correct?
MS. SCHNEIDER: Object to the form. It misstates the records.
A. I don't believe so.
BY MR. GAHNZ:
Q. Let's pull up the record. Showing you Exhibit 16. Do you see the part marked "Result" up at the top?
A. Yes.
Q. "Suicide potential exist." Did I read that correctly?
A. Yes.
Q. And is that the result of the suicide screening that was done by Brown County?
MS. SCHNEIDER: Object to the form.
A. Yes.
MR. GAHNZ: I guess, Counsel, what is the issue with that particular question?

MS. SCHNEIDER: It misstates the testimony in the case as to the outcome of the suicide screening. If you're asking him to read what's on the document, it's on the document.
BY MR. GAHNZ:
Q. Now part of what you did was you looked at the NCCHC standards; correct?
A. Yes.
Q. And what they provide is one of the standards requires that a receiving screening be done; correct?
A. Yes.
Q. There was no receiving screening done in this case; correct?
A. That is correct.
Q. Okay. In this case all that was done was the suicide screening questionnaire and a booking observation report?
A. Yes.
Q. And one of the things that you were provided with has been previously marked as Exhibit No. 5, I'm assuming you have, which is the CCS receiving screening form; correct?
A. Yes.
Q. This is blank and we've not -- it's your

understanding that this was not actually done by Brown County or CCS for Ms. Freiwald; correct?
A. I did not see this, no.
Q. Completed?
A. Yes.
Q. And it should have been done?
MS. SCHNEIDER: Object to the form.
MR. MCGAVER: Join the objection.
A. Again, it's based on their policies and procedures.
BY MR. GAHNZ:
Q. Those are the policies and procedures that were in place indicate that Exhibit 5 should have been completed for Ms. Freiwald?
MS. SCHNEIDER: He's not offering opinions as to Brown County policies.
MR. MCGAVER: I will join the objection.
MR. ROTH: Join the objection.
BY MR. GAHNZ:
Q. Would you give the answer even though the objection has been made?
A. So again, I can't comment on their policies and procedures.
Q. Well, you did, however, indicate that you were basing your opinions based on NCCHC

standards; correct?
A. Yes.
Q. This document is one of the forms that relates to the receiving screening which CCS indicated it did as part of the compliance with NCCHC standards; correct?
MR. ROTH: Objection. The question lacks foundation. Incomplete hypothetical. And it assumes facts not in evidence. It's beyond the scope of this witness's disclosed opinions.
MS. SCHNEIDER: Join in his objections.
MR. MCGAVER: Join.
BY MR. GAHNZ:
Q. You can answer the question.
A. Can you repeat the question?
Q. Let me give you a document to look at. I want you to -- showing you what we previously marked as Exhibit 44. Is that the CCS receiving screening policy?
MR. ROTH: Object; foundation.
MS. SCHNEIDER: Join.
A. Yes.
BY MR. GAHNZ:
Q. At page CCS 47, the last page of that document, do you see where it says references?

A. Yes.
Q. What is it referencing?
A. The NCCHC standards.
Q. So is it your understanding that Exhibit 44 was the CCS policy related to receiving screening for Brown County as in compliance with NCCHC standards?
MS. SCHNEIDER: Object to the form and foundation.
MR. ROTH: Object to the form and foundation.
MR. MCGAVER: Join.
A. So that is what it is here.
BY MR. GAHNZ:
Q. Okay. So on Exhibit 5, there's a number of questions that this form asks, and I want to go through them. One of them is any recent hospitalizations. From your experience in correctional health care, why would this be important information to be at a receiving screening?
MS. SCHNEIDER: Object to the form. It's vague and overly broad. Incomplete hypothetical.
A. So if a person, let's say, had surgery a

couple of days ago and they needed follow-up with a surgeon, and they said that they were hospitalized and needed that check, then obviously you would have to coordinate the follow-up for that.
BY MR. GAHNZ:
Q. Okay. A little bit farther down the page there's a question "Do you now or have you ever had mental health treatment, hospitalization, or were prescribed psych meds." And then over to the right it ask specifically about psychotropic meds. Why is this information important to find for receiving screening?
MS. SCHNEIDER: Object to the form. Vague and overly broad. Incomplete hypothetical.
MR. ROTH: Join.
A. Again, to see if medications needed to be continued or if there needs to be follow-up on certain conditions.
BY MR. GAHNZ:
Q. The next question ask "Have you ever attempted suicide?" why is that question part of the receiving screening?
MS. SCHNEIDER: Object to the form. Incomplete hypothetical.

MR. ROTH: Join. And object to foundation as well the witness interpreting the document.
A. So attempted suicide in the past is a predictor of one of many factors that could predict suicide in the future.
BY MR. GAHNZ:
Q. Isn't a prior suicide attempt the most predictive of future suicide attempts?
MS. SCHNEIDER: Object to the form.
MR. MCGAVER: Join.
A. Based on the literature, yes.
BY MR. GAHNZ:
Q. The second page it talks about "What drugs do you use? If opiates/benzo, immediately refer to medical staff."
Why would a receiving screening provide that information?
MS. SCHNEIDER: Object to the form and foundation.
MR. ROTH: Join.
A. Related to withdrawal symptoms.
BY MR. GAHNZ:
Q. Okay. Is it your understanding that if Exhibit 5 had been filled out on behalf of

Ms. Freiwald would have been provided to the clinical staff, the nurses?

MS. SCHNEIDER: Form and foundation.

MR. MCGAVER: Calls for speculation.

A. Again, I think this is irrelevant even if it was filled out.

BY MR. GAHNZ:

Q. I understand you think it's irrelevant. That's not really my question.

My question is should it have been given to the -- would it have been given to the clinical staff?

MS. SCHNEIDER: Argumentative. Form and foundation.

A. So any clinical information I assume would be given to the clinical staff.

BY MR. GAHNZ:

Q. And the policy provides that in Exhibit 44 that once the receiving screening is filled out it is, in fact, suppose to be provided to the clinical staff; correct?

MS. SCHNEIDER: Form and foundation.

MR. ROTH: Objection. Form and foundation. Beyond the scope of this witness's testimony to interpret or opine on health care

policies.

A. That is what this document states.

BY MR. GAHNZ:

Q. Okay. And presumably had Exhibit 5 been filled out on behalf of Ruth Freiwald, this is information that Dr. Fatoki would have had in hand at the time he was making his decisions?

MS. SCHNEIDER: Object to the form. Foundation.

A. Yes. I assume so.

MR. GAHNZ: Why don't we take a short break.

(WHEREUPON, A BREAK WAS TAKEN AND THE PROCEEDINGS CONTINUED AS FOLLOWS:)

BY MR. GAHNZ:

Q. Doctor, will you turn to page 8 of your original report please?

A. Okay.

Q. Do you know what -- you write that Ms. Freiwald did not exhibit any signs of benzodiazepine withdrawal and the visual observation done to assess this showed no observation that she suffered from tremors or cardiovascular instability. Who did the visual observation of Ms. Freiwald?

A. The correctional officers as well as -- majority is correctional officers.

Q. And is this statement based on the fact that there was nothing reported?

A. And also from the depositions that no one observed her in acute medical distress. And so when you're having life-threatening benzodiazepine withdrawal, it's rather apparent the person is in medical distress.

Q. Okay. Will you pull up Exhibit 241. That's your supplemental report?

A. Yes.

Q. So the first number on page 4 is your comment on Dr. Greist's supplemental report; correct?

A. Yes.

Q. And you indicated that Dr. Greist erroneously attributes the cessation of Clonazepam and Gabapentin to Ms. Freiwald's cause of death; correct?

A. Yes.

Q. And we've talked about this in some detail. But I want to make sure I've given you the opportunity to give all of the reasons why you're critical of Dr. Greist's conclusion to that

effect?

A. Yes.

Q. Is there anything that we haven't covered?

A. Yes. So the literature is very, very clear. If you're going to die from Clonazepam, it's from Clonazepam withdrawal, which essentially gives you cardiovascular instability with rapid heart rate, blood pressure, visual hallucinations and then complete cardiovascular collapse. That is not what has happened in this type of situation.

Two, in terms of if these medications were so egregious and causing like increased suicide ideation and attempts, there would be a black box warning about this similar to anti-depressants where they put a warning that says people who are on anti-depressants can commit suicide. And there is an actual warning there. There is no FDA warning about this. There are studies that can show correlation. But it doesn't show causation. And that's where I think Dr. Greist is trying to show causation with the Clonazepam and Gabapentin, which is just not supported in the literature.

Q. Okay. With respect to suicide, is there a relationship between suicide and people that suffer from a combination of severe depression and anxiety?

MS. SCHNEIDER: Object as vague and overly broad.

MR. MCGAVER: Join.

THE WITNESS: Please repeat it.

(RECORD READ BY THE COURT REPORTER.)

A. So those are risk factors.

BY MR. GAHNZ:

Q. And what, if any, literature research did you do to determine the interplay of depression and anxiety in suicide?

MS. SCHNEIDER: For this case?

BY MR. GAHNZ:

Q. Well, first for this case?

A. So again, it's related to my knowledge based on the other mental health literature, and a lot of the suicide literature that I have reviewed previous to this case. But, again, it's specific about what are the risk factors for suicide. And then what would trigger someone to basically want to have an attempt, what are life triggers as well as what are risk factors from the past medical

history.

Q. Would you agree that if a person's anxiety goes up appreciably that is a suicide risk factor?

MS. SCHNEIDER: Object to the form.

A. Again, it would have to be mixed with other things. Not pure anxiety. More depression would probably be more related to suicide attempts.

BY MR. GAHNZ:

Q. So a person who has severe depression and then whose anxiety increases appreciably is at greater risk for suicide. Is that a fair statement of your knowledge of the literature?

MS. SCHNEIDER: Object to the form.

A. Again, based on the literature they are risk factors.

BY MR. GAHNZ:

Q. You state in the last paragraph under bullet point one, "Her clinical assessments did not show she was actively suicidal for the clinical staff to stop her from leaving the jail to attend the HUBER program."

Who did a clinical assessment of Ms. Freiwald?

A. So, when I'm talking about her clinical assessment I'm talking about the visual observations at which she was voicing. And so to any of the staff she has never made statements that she is actively suicidal. So the term clinical assessment in that type of situation is when she's asked or if she's volunteering that information about having suicidal thoughts or anything else. And she has not voiced that to any of the staff to basically stop her from going to the HUBER program.

And I think this is a really important distinction here because again the jail's responsibility is do they hold this person against the judge's order for the person not to go to the HUBER program. And there are certain indications you would do that. If the person was in acute medical distress or immediate harm to life.

In all of the depositions and visual observation of the staff, there was no indications that she should have been held to go to the HUBER program. And, again, once she is outside of the walls of the jail, she's not the responsibility of the clinical staff of that jail.

Q. I want to make sure I'm understanding

the distinction here. Clinical assessment is that something that you would expect that would be done by a nurse or a physician?

MS. SCHNEIDER: Object to the form.

A. So in terms of this statement, it's also a combination of the correctional officers.

BY MR. GAHNZ:

Q. So that's what my confusion is. Are correctional officers competent to do clinical assessments?

A. So again, to clarify this sentence. The assessment is really the visual observation and whether she is voicing any suicidal ideation or posing any sign of withdrawal. None of that was apparent in any of the materials that I reviewed.

Q. My understanding is the clinical assessment needs to be done by a medical professional?

A. Yes.

Q. And was there any clinical assessment done of Ms. Freiwald during the entire time that she was at Brown County Jail?

MS. SCHNEIDER: Object to the form. That misstates what he's put in his report.

MR. MCGAVER: Join.

A. There was no assessment done by the clinical staff based on the documentation.
BY MR. GAHNZ:
Q. Okay. So when you write her clinical assessment, what you really meant was the guards didn't see anything that gave them pause?
A. Yes. There was no medical distress, signs of withdrawal or active suicidal ideation.
Q. Ms. Freiwald was ordered to have blood pressure checks that were done; correct?
A. Yes.
Q. And those were suppose to be done for the first three days that she was there?
A. Yes.
Q. Those were not done; correct?
MS. SCHNEIDER: Object to the form.
A. I don't believe so.
BY MR. GAHNZ:
Q. That would have given clinical staff the opportunity to actually do an assessment; correct?
A. I would believe so. Yes.
Q. Under .3 you write "What is clear is that the mental health outpatient therapy for Ms. Freiwald only worked when there are no significant triggers in her life."

What did you mean by that?
A. So the months between the February incident and the jail, even though she was getting outpatient therapy, there were no significant trigger events like going through a divorce or personal relationship, loss of a job, or like what ended up happening in this situation where she's incarcerated and her length or perception of her length of stay was different than what her expectation was. So there was no significant trigger in those months to really say that this therapy was working.
And not to minimize what happened here, but for someone to go into the jail thinking they will be there for a day but then having to be there for 30 days, and will be going in and outside of the jail, for them to not have a coping mechanism and then to jump in front of a vehicle while she is unsupervised, I think that it clearly shows that outpatient mental health treatment didn't give her the skillsets to obviously cope with this type of situation.
Even though for most people when they're going to commit suicide, the real risk factor is they get 10 years, 20 years, 30 years, life

sentences. That's typically what we see in this type of situation. For such a short period of incarceration, it seems like her coping mechanisms were extremely poor.
Q. Okay. What is your understanding of the therapy that she was receiving between February and October of 2016?
A. I think it was those medications. So it would be these outpatient medications.
Q. Was she getting any other therapy?
A. And then talking with somebody, with the licensed mental health person.
Q. And really my specific question is what was the role of the Dawn Vardia in the time period between February of '16 and October of '16?
MS. SCHNEIDER: Object to the form as to the word role. But go ahead if you understand.
BY MR. GAHNZ:
Q. Let me rephrase the question. That's fine.
What treatment was Dawn Vardia providing to Ms. Freiwald between February of '16 and October of '16?
A. Counseling.
Q. For what?

A. For her mental health conditions.
Q. Do you recall any of the specifics of that?
A. I'd have to go through it. But it was really with her PTSD, her depression. And her anxiety was related to those conditions.
Q. And do you recall whether or not Ms. Vardia was providing behavioral therapy related to the PTSD issues?
A. I believe she was.
Q. Do you recall that Ms. Vardia was having Ms. Freiwald relive sexual abuse by her father during that time frame?
A. I believe that was in the medical records.
Q. Did you read Dawn Vardia's notes as it related to how Ms. Freiwald reacted to the behavior therapy involving the sexual abuse by her father?
A. I don't remember the reaction. I just remember reading all of the prior history of what caused the PTSD.
Q. Would that in your opinion be a significant trigger in somebody's life to go through and to confront the sexual abuse by one's

father?

MS. SCHNEIDER: Object to the form.

A. Again, in this situation I think the trigger, and its pretty clear based on the records and everything else, it was her being incarcerated and actually having a different expectation of her incarceration that created this incident where she became impulsive and tried to harm herself.

BY MR. GAHNZ:

Q. I understand we're talking about after October 27th. I'm talking about during the time frame when she was out. Is confronting sexual abuse by one's father a significant trigger in somebody's life?

MS. SCHNEIDER: Object to the form.

A. It's in a very controlled setting with the outpatient mental health clinician. So I would think it's actually safer in that venue with somebody she has developed a relationship, knows and trust. So I think it's a safe environment. If a regular person was to bring that out, it could have been a much -- it could have been a life trigger.

BY MR. GAHNZ:

Q. At page 5 you wrote her prescription of

Clonazepam, which in her case caused a serious suicide attempt. Is it your understanding -- is it your testimony that the fact that she was on Clonazepam caused a serious suicide attempt?

MS. SCHNEIDER: Misstates his earlier testimony.

BY MR. GAHNZ:

Q. That's why I'm asking.

A. My thing basically states that she overdosed on 90 pills of Clonazepam. She used what was available to her to try and harm herself. And so that is the pills that she used. It wasn't the Clonazepam that -- because it doesn't look like it was the Clonazepam as much as a method to try to harm herself.

Q. I just wanted to make sure the sentence -- that I was understanding the sentence correctly. What you're meaning by this statement her prescription of Clonazepam, which in her case caused a serious suicide attempt is that the Clonazepam was the methodology by which she attempted to suicide?

A. Yes.

Q. Not that because she was on Clonazepam she became suicidal?

A. That is correct.

Q. Okay. In medical terms when somebody uses the phrase "classic signs" is that a term of art for medication in medicine?

MS. SCHNEIDER: Object to the form.

A. Yeah. I've heard the term before.

BY MR. GAHNZ:

Q. What does it mean?

A. That certain, let's say, symptoms would be classic. So a good example would be classic signs of a flu is fever, body aches, cough.

Q. And that means that it's across the population of people that have the flu, the classic signs would be fever, etc.?

A. Yes.

Q. It's not -- okay. I think you had stated this earlier but I just want to see if you agree with this that benzodiazepine withdrawal develops within a few days of stopping benzodiazepines?

A. Typically the peak of symptoms are 48 to 72 hours.

Q. Would you agree that the most prominent symptom of benzodiazepine withdrawal is rebound anxiety?

MS. SCHNEIDER: Objection. Asked and answer.

A. The most prominent is elevated heart rate, blood pressure, sweating, tremors, and then obviously anxiety as part of that.

BY MR. GAHNZ:

Q. Would you agree that the CIWA-B states the constellation of symptoms that one could expect from benzodiazepine withdrawal?

A. Yes.

Q. Is it important to know how long somebody has been on benzodiazepine when making a determination as to whether or not to continue the prescription?

MS. SCHNEIDER: Object to the form. Vague and overly broad.

A. So the duration of the benzodiazepine is important to know if withdrawal symptoms are going to happen to begin with and how severe.

BY MR. GAHNZ:

Q. And are there categories? You know, so is there a difference if somebody has been on it for a week, versus six months, versus six years, is it categorized in terms of the level of dependence that somebody is going to have?

A. So typically the longer the person is on it, the more tolerant they are to it and more dependent they are. So the withdrawal will sometimes happen on a more sooner basis than on a latter basis.

Q. Okay. If somebody is thought to be a suicide risk, whose responsibility of Brown County was it to refer them for further follow-up?

MS. SCHNEIDER: Object to the form.

MR. MCGAVER: Join.

MR. ROTH: Join.

A. So I believe Brown County had -- again, I can't speak on Brown County's mental health policies because I haven't reviewed the contract.

BY MR. GAHNZ:

Q. Did Dr. Fatoki have any responsibility with respect to the inmates at Brown County to review the suicide screening form to determine whether or not they were a suicide risk?

MS. SCHNEIDER: Object to the form. Incomplete hypothetical.

A. I don't believe he was -- I believe his primary focus was on the medical side and not on the mental health side unless it went into the medical.

BY MR. GAHNZ:

Q. Okay. Do you know whether or not Ms. Freiwald was exhibiting any respiratory issues while she was incarcerated at Brown County?

A. I don't believe she was in any respiratory distress.

Q. Same question with respect to the time frame between February of 2016 and October of 2016, do you know, was there any evidence that you saw in any of the medical records that she was having any respiratory issues?

A. So I don't believe she was having any respiratory issues. I don't remember if she hyperventilated, if you're considering that respiratory issues.

Q. We've talked about previous suicides being a predictor of future suicide?

A. Yes.

Q. Is there a time frame that a medical professional is concerned about in terms of the recency of the prior attempt?

A. So the Columbia Suicide Severity Scale has a time frame on it. I think within the past month is very, very significant where it triggers it. But I think it says within three months, and

then I think lifetime. But I think it's within just a few months.

Q. So it's most severe within a month?

A. Well, based on that tool.

Q. What is that called again?

A. The Columbia Suicide Severity Scale. And that's a clinically validated tool that a lot of jurisdictions use for suicide screening.

Q. Do you know whether or not that Columbia Suicide Severity Scale was used by CCS in Brown County?

A. I don't believe so.

Q. Do you know what scale they used to determine whether somebody was a suicide risk or not?

A. I think it was -- again, I think it's the suicide screening questionnaire.

Q. Okay. Do you agree that a person in Ms. Freiwald's situation was in more danger -- strike that question.

The monitoring that you were talking about if somebody is taken off of benzodiazepine abruptly, is that normally done in an inpatient setting?

MS. SCHNEIDER: Object to the form.

Vague.

A. So it's done where there is people that can observe the patient's appearance, behavior, and can communicate with the patient.

BY MR. GAHNZ:

Q. And so in the community, for instance, if you're to stop somebody from -- as a prescriber if a patient comes to you and they're on benzodiazepine, you're not going to stop them abruptly because they go home and there's nobody to watch them and monitor them; correct?

A. So in that type of situation there's nobody to monitor or watch, typically you would just prescribe them a taper, you would not admit them to monitor.

Q. And in the clinical setting people are physically trained to look for benzodiazepine withdrawal symptoms; correct?

A. Again, it's similar to alcohol withdrawals. So it would be the same picture.

Q. Going back to your report the timeline, you indicated that you reviewed a couple of medical request slips from Ms. Freiwald on the 28th that she had provided on the 28th and 29th; correct?

A. Yes.
Q. Was she requesting health services at that point?
A. She was requesting I believe the medications.
Q. Was she describing symptoms that -- was she describing clinical symptoms in either of those requests?
A. Yes.
Q. Do you know whether or not there was any face-to-face encounters as a result of those two requests by any nurse from CCS?
A. I know it's stated that the nurse responded to the inmate request form. But I don't know if it was face-to-face.
Q. In looking at the NCCHC standards, did you review the J-G-02 standard which has been previously marked as Exhibit 227?
A. Yes. I am aware of this standard.
Q. Did Ms. Freiwald meet the definition of a patient with special needs pursuant to this standard?
A. No.
Q. So if you look at page 2, which is she had a depressive disorder; is that correct?

special needs; correct?
MS. SCHNEIDER: Object to the form. It's been asked and answered.
A. Again, from what I'm looking at from this special health needs it says individualized treatment plan. It's basically based on Dr. Fatoki's assessment. So, yes if you want to go with this very broad definition and treatment plan, I would say that it would technically meet this. But it's not for the purposes of the actual depression and everything else. There is a treatment plan, so it was actually done. But I wouldn't consider this like a special needs case.
MR. GAHNZ: That's all the questions that I have.
MR. MCGAVER: I have no questions.
MS. SCHNEIDER: Andy, do you have any questions?
MR. ROTH: Not for me. Thanks.
EXAMINATION
BY MS. SCHNEIDER:
Q. I just have a couple of clarification questions.
Doctor, you were asked earlier about whether or not there's the risk of

A. Yes.
Q. She had tried to self-injure?
A. Yes.
Q. And she had post-traumatic stress disorder?
A. Yes.
Q. She also had a recent hospitalization; is that correct?
A. Yes.
MS. SCHNEIDER: Object to the form.
BY MR. GAHNZ:
Q. I'm sorry?
A. Yes.
Q. These are all indicative of a patient with special needs; correct?
MS. SCHNEIDER: Object to the form.
BY MR. GAHNZ:
Q. According to the standard?
A. So based on this, I would say she's prescribed an anti-depressant by Dr. Fatoki. And so as a result the depression is essentially treated.
Q. I appreciate that. My question was a little bit different. Based on this standard Ms. Freiwald met the definition of a patient with

life-threatening withdrawal with abruptly stopping benzodiazepine. Do you recall that?
A. Yes.
Q. And that varies depending on dosage and how long someone is on the medication?
A. Yes.
Q. And in Ruth Freiwald's case, she did not develop any life-threatening withdrawal symptoms; is that your testimony?
A. Yes.
Q. You were asked a little bit about the receiving screening and the CCS policy. You were not provided with the receiving screening policy; is that correct?
A. Not prior to today.
Q. And in terms of rendering any opinions on that, you would want to see the policy before you gave an opinion in that regard?
A. Yes.
Q. And you just haven't been asked to look at that aspect of the case; fair?
A. That is correct.
Q. And then you were asked a little bit about the as-needed dosage of the Clonazepam. Do you recall that?

A. Yes.
Q. You weren't indicating that Ms. Freiwald was taking three to four milligrams of Clonazepam a day; is that correct?
A. No. It was basically she's prescribed one milligram a day with 0.5 milligrams as needed. So you could get up to that dosage if she took it multiple times a day.
Q. Your understanding was that she was taking one to one and-a-half milligrams a day?
A. Yes.
MS. SCHNEIDER: That is all I have.
FURTHER EXAMINATION
BY MR. GAHNZ:
Q. Doctor, I want to show you what's been previously marked as Exhibit 228. That's the NCCHC standards for receiving screening; correct?
A. Yes.
Q. You have reviewed that document as part of your work in this case; correct?
A. Yes.
Q. This document at .6, do you see that?
A. Yes.
Q. It says that "The receiving screening form is approved by the responsible health

authority and inquires as to the inmate's," and then it list a whole series of things; correct?
A. Yes.
Q. So Exhibit 5 which we went through is, in fact, the receiving screening form that was created for Brown County; correct?
A. Yes.
MR. ROTH: Object to foundation and to the form.
MS. SCHNEIDER: Join.
BY MR. GAHNZ:
Q. It's your understanding that this receiving screening form, Exhibit 5, was created in an effort to comply with the standard set forth in Exhibit 228?
MS. SCHNEIDER: Form.
MR. ROTH: Objection. Foundation. Calls for the witness to speculate.
MS. SCHNEIDER: Join.
A. So I cannot answer that question because I don't know the reason, if that was directly related to the standard.
BY MR. GAHNZ:
Q. Okay. It does, however, state at the top that this is the receiving screening form on

Exhibit 5?
A. That is what it says.
MR. GAHNZ: That's all.
MS. SCHNEIDER: We're done.
(The deposition concluded at 11:05 a.m.)

Declaration Under Penalty of Perjury

I, ALFRED JOSHUA, M.D., the witness herein, declare under penalty of perjury that I have read the foregoing in its entirety; and that the testimony contained therein, as corrected by me, is a true and accurate transcription of my testimony elicited at said time and place.

Executed this_____day of ____20__, at _____,_____.
(city) (state)

_____
ALFRED JOSHUA, M.D.

I, BOBBIE HIBBLER, Certified Shorthand Reporter, in and for the State of California, Certificate No. 12475, do hereby certify as follows:

That the witness in the foregoing deposition was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the foregoing cause; that the deposition was then reported by me in shorthand and transcribed, through computer-aided transcription, under my direction; and that the above and foregoing deposition transcript is a true and accurate record of the witness' testimony elicited and proceedings had at said deposition.

Further, that if the foregoing pertains to the original transcript of deposiion in a Federal case, before completion of the proceedings, review of the transcript [ ] was [x] was not requested.

I do further certify I am neither financially interested in the action nor a relative or employee of any attorney or party to this action.

In witness whereof, I have hereunto set my hand this _____ day of _____, _____.

_____

BOBBIE HIBBLER, CSR No. 12475

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